Interdisciplinary Care Management Form
Pre-admission/Pre-screening Data

This form should be completed for new admissions or changes in patient information. Upon completion of this form you can choose to either fax or submit a hard copy to the appropriate location listed below:

	Room#	Fax #	CSA/RSA Phone #
1NW Inpatient-	1-1655	(301) 480-3137	(301) 451-0345
1NW Day Hospital	1-2625	(301) 480-1063	(301) 451-7727
1SE (H) Peds Clinic	1-6444	(301) 480- 3714	(301) 451-9229

To ensure patient confidentiality, if you choose to fax the form, please call the CSA/RSA of the unit, clinic or day hospital to alert them of the pending arrival.

If the patient is to be seen in both the day hospital and clinic, please send the form to the area the patient is to be seen on day one of the episode of care. (An episode of care is defined as a group of consecutive visits within one to two week period)

Required fields*

☐ * Pediatric Inpatient
☐ * Pediatric Day Hospital

☐ * Pediatric Clinic (Select room type)
☐ * Interview Room
☐ * Exam room
☐ * No preference

General Information: Information should be completed for each episode of care.

*Name: Last _____ First _____ Middle _____

Mailing Address (new admit or change) _____ Gender: ☐ F ☐ M

Contact Phone # _____ (New admit or change)

Email Address _____ (New admit or change)

*MRN _____ SS# _____ *DOB/Age _____

*Protocol # _____ *Cycle/Visit # (if applicable _____ *Diagnosis _____

*PI/Team: _____ *Fellow _____

* Date of admission/visit: _____ * Date of discharge: _____

*Person completing form: _____ Contact number: _____

*Person to be notified when patient arrives: _____ *Phone #: _____

*Beeper #: _____

Date of Travel _____ Date of Departure _____

Mode ☐ Plane ☐ Car ☐ Other: _____

(Please Complete the Back Side of the Form)

Housing needed:	☐ **Y**	☐ **N**	
If Yes:	☐ **Children's Inn Referral**	☐ **Hotel (name):**	
Person accompanying patient:			
Isolation needed:	☐ **Y**	☐ **N**	

Tests/Procedures Planned: Include date and time for each

	Activity	Procedure / Site / Med:	Date/Time		Activity:	Date/Time
☐	**Sedation** for:			☐	**Lumbar Puncture**	
☐	**Skin Punch Biopsy**			☐	**Complex blood draw**	
☐	**Infusion of:**			☐	**Anesthesia Card Needed**	
☐	**Bone Marrow Biopsy**			☐	**Anesthesia Card Completed**	
☐	**Serial Blood Testing**			☐	**Other**	

Special Needs:

	Patient Equipment			Dietary Needs		
☐	**VAD (type and size):**		☐	**Formula**		**brand**
☐	**Trach (type and size):**		☐	**Low-Fat**		**kcal**
☐	**Bi-Pap:**		☐	**Kosher**		
☐	**C-Pap:**		☐	**Vegetarian**		**type**
☐	**G tube (type and size):**		☐	**Diabetic**		**kcal**
☐	**Other**		☐	**Other**		

Assistive Devices Needed

☐	**Seeing Eye dog**	☐ **Companion dog**	☐	**TTY**	
☐	**Interpreter (language)**		☐	**Interpreter arranged**	
☐	**Wheelchair**		☐	**Bringing own wheelchair**	
☐	**Stroller**		☐	**Bringing own stroller**	
☐	**Bathroom Aids**	☐ **Bed away from window**	☐	**Other**	

Please attach any additional information.

(Please Complete the Back Side of the Form)